S. 1947

To amend title XI of the Social Security Act to improve the quality improvement organization (QIO) program.

IN THE SENATE OF THE UNITED STATES

AUGUST 2, 2007

Mr. GRASSLEY (for himself and Mr. BAUCUS) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XI of the Social Security Act to improve the quality improvement organization (QIO) program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Continuing the Advancement of Quality Improvement Act of 2007”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Responsibilities of utilization and quality control peer review organizations.
Sec. 3. Priorities for selection of providers to provide technical assistance.
Sec. 4. Data processing.
SEC. 2. RESPONSIBILITIES OF UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS.

(a) Responsibilities.—

(1) In general.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3) is amended by adding at the end the following new subsection:

“(g) Notwithstanding the preceding provisions of this section, beginning on August 1, 2009, any utilization and quality control peer review organization entering into a contract with the Secretary under this part shall only perform the function of providing technical assistance for quality improvement and performance measurement to providers, practitioners, and Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII, including the following:

“(1) Instruction on how to collect, aggregate, and interpret data on measures that may be used for internal quality improvement, public reporting, and payment.

“(2) Instruction on how to conduct root-cause analyses and deep case studies of sentinel events and other problems.
“(3) Assistance to improve the validity and accuracy of data submitted by providers and practitioners who participate in the program under title XVIII.

“(4) Advice and guidance on how to bring about, sustain, and diffuse internal system redesign and process changes, particularly those redesign and process changes that—

“(A) are related to the use of information technology for quality improvement; and

“(B) promote care coordination and efficiency through an episode of care.

“(5) Promotion of best practices identified by research, provider, and industry groups.

“(6) Improvement of, and provision of technical support for, the direct role of providers in the education of individuals eligible for benefits under the program under title XVIII as an integral component of improved care, better patient experience, and patient self-management.

“(7) Assistance with bringing together and promoting cooperation among various stakeholders in providing care.”.
(2) CONFORMING AMENDMENTS.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3) is amended—

(A) in the heading, by inserting “AND OTHER ORGANIZATIONS” after “ORGANIZATIONS”; and

(B) in subsection (a)—

(i) in paragraph (1), in the matter preceding subparagraph (A)—

(I) by inserting “of such title” after “part C”; and

(II) by inserting “of such title” after “part D”; and

(ii) in paragraph (17)—

(I) by inserting “of title XVIII” after “part C”; and

(II) by inserting “of such title” after “part D”.

(b) TRANSFER OF RESPONSIBILITIES FOR PERFORMING OTHER FUNCTIONS.—Part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.) is amended by adding at the end the following new section:

“SEC. 1164. TRANSFER OF RESPONSIBILITY FOR PERFORMING CERTAIN FUNCTIONS.

“(a) IN GENERAL.—
“(1) TRANSITION PLAN.—Not later than 6 months after the date of enactment of this section, the Secretary shall develop and transmit to the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the House of Representatives a transition plan under which the functions of utilization and quality control peer review organizations under section 1154, as in effect on the day before such date of enactment, are transferred from the responsibility of such organizations to other agencies and organizations (in this part referred to as ‘Medicare provider review organizations’). The transition plan shall include a description of the steps the Secretary will take in implementing the plan and a timeline for such implementation. The transition plan shall be developed in a manner that will ensure that the intended beneficiaries of the functions transferred will neither be harmed as a result of such transfer of responsibility nor experience a disruption or decrease in services under section 1154.

“(2) MEDICARE PROVIDER REVIEW ORGANIZATIONS.—In determining which agency or organization the responsibility for a function is transferred to under the transition plan implemented under
paragraph (1), the Secretary shall take into account the following considerations:

“(A) Whether the agency or organization is comparable (in terms of experience, capabilities, and capacity) to the organization that performed such responsibilities as of the day before such date of enactment.

“(B) Whether the agency or organization is able to ensure that at least the same level of access to services is available when responsibilities are transferred to the agency or organization.

“(C) Whether the transfer of responsibility to the agency or organization will ensure the least amount of disruption and minimize both the risk of harm to the intended beneficiaries of the transferred responsibilities and the disruption or decrease in services under section 1154.

“(D) In the case where the responsibility transferred is a review function required under section 1154 as of the day before such date of enactment, whether the agency or organization is able, in the judgment of the Secretary, to perform such review function in a manner con-
sistent with the efficient and effective administration of this part.

“(E) Whether the transferred responsibilities would be most effectively and efficiently performed at a nationwide, Statewide, or regional level.

“(F) Whether the transfer of responsibility to the agency or organization will not result in a conflict of interest.

“(3) LIMITATION.—A utilization and quality control peer review organization may not be a Medicare provider review organization in any area in which the utilization and quality control peer review organization provides technical assistance under section 1154(g).

“(4) TRANSFER OF RESPONSIBILITY.—Not later than July 31, 2009, the Secretary shall fully implement the transition plan under this subsection and transfer the functions described in paragraph (1) from utilization and quality control peer review organizations to Medicare provider review organizations.

“(b) SHARING OF INFORMATION WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS.—The Secretary shall develop and implement a
process by which a Medicare provider review organization that, as a result of the transfer of responsibility under subsection (a), conducts case review or has responsibility for addressing beneficiary appeals or beneficiary complaints shares information with utilization and quality control peer review organizations for purposes of providing technical assistance for quality improvement and performance measurement under section 1154(g).”.

(e) Medicare Provider Review Organizations Addressing Beneficiary Complaints.—

(1) IN GENERAL.—Section 1164 of the Social Security Act, as added by subsection (b), is amended by adding at the end the following new subsection:

“(c) Medicare Quality Accountability Program.—On or after the date on which the transition plan is fully implemented under subsection (a), a Medicare provider review organization that has responsibility for addressing beneficiary complaints shall, instead of the requirements described in paragraph (14) of section 1154(a), meet the following requirements:

“(1) Complaint review.—The Medicare provider review organization shall conduct a review of all complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized stand-
ards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual’s behalf). Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the provider, practitioner, plan, or person concerned with reasonable notice and opportunity for comment and discussion.

“(2) Medicare Quality Accountability Program.—The Medicare provider review organization shall establish and operate a Medicare quality accountability program consistent with the following:

“(A) The organization shall actively educate Medicare beneficiaries in an efficient and effective manner of their right to bring quality concerns to such Medicare provider review organizations.

“(B) The organization shall report all findings of its investigations to the beneficiary involved or a representative of such beneficiary, regardless of whether such findings involve a provider, practitioner, or plan. Such reports shall describe, at a minimum, whether the organization confirms the allegations in the com-
plaint and any actions taken by the provider, practitioner, or plan, respectively, with respect to such findings. Such reports, and any other documentation prepared by the organization during the course of investigating complaints, may not be used in a tort claim or cause of action arising under State law.

“(C) The organization shall determine whether the complaint allegations about clinical quality of care are confirmed. In the case where such allegations are confirmed, in whole or in part, the organization shall (based on criteria issued by the Secretary) refer the provider, practitioner, or plan to 1 or both of the following:

“(i) A utilization and quality control peer review organization with a contract with the Secretary under this part for technical assistance under section 1154(g).

“(ii) The appropriate regulatory body for sanctions.

“(D) The organization shall publish and submit to the Secretary annual reports in each State in which the organization operates. Such reports shall include aggregate complaint data
(including the number, nature, and disposition of complaints) and a description of any follow-up activity conducted with respect to such complaints.

“(E) The organization shall promote beneficiary awareness of standardized quality measures that may be used for evaluating care and for choosing providers, practitioners, and plans.”.

(2) Conforming Amendment.—Section 1154(a)(14) of the Social Security Act (42 U.S.C. 1320c–3(a)(14)) is amended by striking “The organization” and inserting “Subject to section 1164(c), the organization”.

(d) Reference to Agencies and Organizations Performing Transferred Functions.—Section 1164 of the Social Security Act, as added by subsection (b) and amended by subsection (c), is amended by adding at the end the following new subsection:

“(d) Reference to Agencies and Organizations Performing Transferred Functions.—On and after the date on which the transition plan is fully implemented under subsection (a), any reference in this Act to a utilization and quality control peer review organization, a peer review organization, an organization, or organizations with
respect to the performance of functions for which responsibility has been transferred under such subsection, shall be deemed a reference to the Medicare provider review organization to which such responsibility has been transferred.

In the case where such a reference is deemed a reference to a Medicare provider review organization, the Medicare provider review organization shall not be required to meet—

“(1) the definition of a utilization and quality control peer review organization under section 1152 (as amended by section 5 of the Continuing the Advancement of Quality Improvement Act of 2007); or

“(2) contract requirements applicable to a utilization and quality control peer review organization under section 1153 (as amended by such section 5).”.

SEC. 3. PRIORITIES FOR SELECTION OF PROVIDERS TO PROVIDE TECHNICAL ASSISTANCE.

Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended by adding at the end the following new subsection:

“(j) The Secretary shall establish priorities for utilization and quality control peer review organizations to use in selecting providers and practitioners to provide technical assistance under section 1154(g) in the event de-
mand for such assistance exceeds the available resources of such organizations. The priorities established shall include—

“(1) whether the provider or practitioner is located in a rural or underserved area;

“(2) the financial needs of the provider or practitioner;

“(3) low performance in measures that may be used for public reporting and payment;

“(4) whether there has been a significant number of beneficiary complaints with respect to the practitioner or provider; and

“(5) such other measures of performance or quality as are available to the Secretary.”.

SEC. 4. DATA PROCESSING.

(a) In General.—Section 1160 of the Social Security Act (42 U.S.C. 1320c–9) is amended—

(1) in subsection (a)(3), by striking “subsection (b)” and inserting “subsections (b) and (f)”;

(2) by adding at the end the following new subsection:

“(f)(1) A utilization and quality control peer review organization and a Medicare provider review organization may share individual-specific data obtained from another provider or practitioner with a provider or practitioner
who is treating the individual, for quality improvement
and patient safety purposes.

“(2) A utilization and quality control peer review or-
ganization and a Medicare provider review organization
may share provider-specific data with the Secretary.

“(3) The Secretary shall promulgate, not later than
1 year after the date of the enactment of this subsection,
a regulation that—

“(A) specifies the process for sharing data
under paragraphs (1) and (2); and

“(B) includes safeguards to ensure the con-
fidentiality of the data shared.

“(4) Nothing in this subsection shall be construed to
limit, alter, or affect the requirements imposed by the reg-
ulations promulgated under section 264(c) of the Health
Insurance Portability and Accountability Act of 1996.”.

(b) COMPREHENSIVE REVIEW.—

(1) IN GENERAL.—The Secretary of Health and
Human Services (in this section referred to as the
“Secretary”’) shall conduct a comprehensive review
of the data-sharing systems, processes, and regula-
tions of the Department of Health and Human Serv-
ices in order to—

(A) identify best practices and procedures,
including abstraction of medical chart data; and
(B) ensure that such systems, processes, and regulations do not—

(i) restrict the sharing of data by utilization and quality control peer review organizations with a contract under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.) for quality improvement and patient safety purposes; or

(ii) inhibit prompt feedback to such organizations and to providers, practitioners, and Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the performance of such providers, practitioners, and organizations.

(2) REPORT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit a detailed report to the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the House of Representatives containing—

(A) the results of the review conducted under paragraph (1);
(B) a timeline for the implementation of any administrative action the Secretary determines to be appropriate; and

(C) recommendations for such legislation as the Secretary determines to be appropriate.

(e) Supporting National Reporting and Integrating Care Data.—The Secretary shall ensure that the program under part B of title XI of the Social Security Act, as amended by this Act, supports the processes of national reporting of performance measures, data aggregation, data analysis, and feedback.

SEC. 5. QUALIFICATIONS FOR UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS.

(a) Removal of Physician-Access and Physician-Sponsored Requirements.—

(1) In general.—Section 1152 of the Social Security Act (42 U.S.C. 1320c–1) is amended by striking paragraph (1) and inserting the following:

“(1) has expertise in quality improvement and performance measurement; and”.

(2) Conforming amendment.—Section 1153(b)(1) of the Social Security Act (42 U.S.C. 1320c–2(b)(1)) is amended by striking the second sentence.
(b) QUALIFICATIONS.—Part B of title XI of the Social Security Act (42 U.S.C. 1320c), as amended by section 3, is amended—

(1) in section 1152—

(A) by striking paragraph (2);

(B) by redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2), as redesignated by subparagraph (B), by inserting “and, beginning on the date that is 1 year after the date of enactment of the Continuing the Advancement of Quality Improvement Act of 2007, that meets the requirements described in section 1153(k)(1)” before the period at the end; and

(2) in section 1153, by adding at the end the following new subsection:

“(k)(1) The requirements described in this paragraph are as follows:

“(A) The governing board of the utilization and quality control peer review organization is appropriately diverse, has relationships with providers and stakeholders within the State, and provides for transparency.

“(B)(i) Subject to clause (ii), the governing board of the utilization and quality control peer re-
view organization is made up of individuals from diverse areas, disciplines, and expertise, including—

“(I) quality improvement and performance measurement professionals from within and outside of the health care field;

“(II) providers of services under the program under title XVIII, including physicians and other health care practitioners;

“(III) public or population health professionals;

“(IV) information technology implementation, management, and oversight professionals;

“(V) certified public accountants, auditors, and attorneys; and

“(VI) Medicare beneficiary and consumer groups.

“(ii) A majority of the members of the governing board of the utilization and quality control peer review organization do not come from any 1 of the 5 areas, disciplines, and expertise described in subclauses (I) through (V) of clause (i).

“(C) The governing board of the utilization and quality control peer review organization has—

“(i) developed and implemented a compliance program that includes—
“(I) written policies, procedures, and standards of conduct that articulate the organization’s commitment to comply with all applicable Federal and State standards;

“(II) effective compliance training and education for employees, managers, and members of the governing board;

“(III) the designation of—

“(aa) a compliance officer; and

“(bb) a compliance committee comprised of a majority of members who are independent of the governing board and to which the governing board refers issues of conflicts of interest, ethics, program integrity, and the compensation (including benefits) and travel costs of senior executive staff and members of the governing board;

“(IV) effective lines of communication between the compliance officer designated under subclause (III)(aa) and the organization’s employees;
“(V) enforcement of policies, procedures, and standards of conduct through publicized disciplinary guidelines;
“(VI) procedures for periodic internal monitoring and auditing;
“(VII) procedures for ensuring prompt response to detected offenses and the development of corrective action initiatives; and
“(VIII) such other requirements as the Secretary determines to be necessary for ensuring appropriate governance; and
“(D) The governing board of the utilization and quality control peer review organization and the utilization and quality control peer review organization comply with the following requirements for transparency and accountability:
“(i) The governing board of the utilization and quality control peer review organization discloses to the public information regarding the board, including—
“(I) the size of the board;
“(II) the length of appointment of members to the board;

“(III) any cap on the length of service as a member of the board;

“(IV) when appointments to the board are made;

“(V) what portion of the board is typically appointed each year;

“(VI) names, affiliation, and compensation of board members; and

“(VII) such other disclosure requirements as the Secretary determines to be appropriate.

“(ii) The governing board of the utilization and quality control peer review organization meets contract requirements developed by the Secretary—

“(I) with respect to the length of service, independence, and duties of board members; and

“(II) with respect to compliance officer and compliance committee duties.

“(iii) The governing board of the utilization and quality control peer review organization complies with guidelines developed by the
Secretary as to what constitutes reasonable compensation for members of the governing board of a utilization and quality control peer review organization (including the chief executive officer, chief operating officer, and chief financial officer).

“(iv) The utilization and quality control peer review organization has in place formal and documented procedures for addressing potential board member and executive conflicts of interests, ethical issues, and program integrity.

“(v) The utilization and quality control peer review organization implements formal and documented procedures to evaluate individual board member actions and activities and overall board performance not less frequently than on an annual basis.

“(2) Each contract with a utilization and quality control peer review organization under this part shall require that the organization comply with a system established by the Secretary to identify, cure (by resolving or waiving), and report conflicts of interest with respect to the governing board of such an organization, such organization, and entities that subcontract with such organization. Such system shall include the following:
“(A) Guidelines as to what constitutes a conflict of interest, including a member of the governing board receiving compensation from the organization, directly or indirectly, for the provision of services outside the scope of their duties and responsibilities as a member of the governing board.

“(B) The requirement to disclose any potential conflicts of interest.

“(C) A process by which conflicts of interest shall be disclosed.

“(D) Methods by which conflicts of interest shall be resolved or waived.

“(3) Each contract with a utilization and quality control peer review organization under this part shall require that the organization meet requirements pertaining to the development and conduct or implementation of—

“(A) annual performance evaluations for members of the governing board of such an organization (including the chief executive officer, chief operating officer, and chief financial officer);

“(B) an annual self-assessment to be conducted by the governing board of such an organization; and

“(C) an overall performance improvement plan for the governing board of such an organization.”.
(c) Duration of Contracts, Selection Criteria, and Ensuring Value.—Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended—

(1) by striking paragraph (3) of subsection (c) and inserting the following new paragraph:

“(3) contract terms are consistent with subsection (i);”; and

(2) by striking subsection (i) and inserting the following new subsection:

“(i)(1) Subject to the succeeding provisions of this subsection, each contract with a utilization and quality control peer review organization under this part shall be for an initial term of 5 years, beginning and ending on a common date for all contractors as required under this subsection and shall be renewable for 5-year terms thereafter.

“(2) Each contract with a utilization and quality control peer review organization under this part—

“(A) shall be bid on through a competitive process; and

“(B) shall not be renewed without going through a competitive process.

“(3) The Secretary shall use criteria for selecting utilization and quality control peer review organizations to
enter into a contract with under this part that takes into
consideration—

“(A) any previous experience and performance
of the organization under a contract under this part;
“(B) whether the organization has dem-
onstrated a capacity to support quality improvement
and performance measurement; and
“(C) the financial integrity of the organization.
“(4) The Secretary shall develop performance meas-
ures, including interim and final goals, for the functions
to be performed by the utilization and quality control peer
review organization under the contract. The performance
measures shall be based on nationwide priorities developed
or adopted by the Secretary. Such measures shall be made
available to utilization and quality control peer review or-
ganizations during the bidding process. The Secretary
shall provide financial incentives and penalties that reward
high performance and penalize poor performance under
such contracts, taking into consideration the measures de-
veloped under this paragraph.
“(5) The Secretary shall develop procedures for the
conduct of interim and final evaluations to assess the per-
formance of the utilization and quality control peer review
organization under the contract against the performance
measures developed under paragraph (4). Such procedures
shall provide for 3 types of evaluations to be conducted at each of the following levels:

“(A) The program under this part as a whole.

“(B) Individual utilization and quality control peer review organizations with respect to the contract entered into with such organization under this part.

“(C) Selected quality improvement interventions implemented by such organizations.

“(6) The Secretary shall enter into a contract with an entity to conduct an independent external evaluation of the overall contributions of the program under this part toward quality improvement and performance measurement. Such an evaluation shall be conducted not less frequently than once during each contract cycle.

“(7) The Secretary shall extend each contract with a utilization and quality control peer review organization under this part the contract period for which began on or after August 1, 2005, and on or before February 1, 2006, so that the subsequent contract period begins on August 1, 2009.”.

(d) SCOPE OF WORK.—Section 1153 of the Social Security Act (42 U.S.C. 1320c–2), as amended by subsections (b) and (c), is amended—
(1) in paragraph (3) of subsection (c), by striking “subsection (i)” and inserting “subsections (i) and (l)”;

and

(2) by adding at the end the following new subsection:

“(l)(1) The scope of work required under a contract with a utilization and quality control peer review organization under this part shall reflect the priorities of—

“(A) quality improvement in individual provider settings and across multiple-provider settings; and

“(B) performance measurement which may be used for purposes of public reporting and payment under title XVIII.

“(2) In advance of each contract cycle, the Secretary shall conduct an assessment of the need for technical assistance for quality improvement and performance measurement by obtaining feedback from providers within each provider setting under the program under title XVIII. The feedback obtained shall be on applicable areas, including the following:

“(A) Internal capacities of providers for quality improvement and performance measurement.

“(B) Past and current quality improvement and performance measurement activities.
“(C) Technical assistance that providers are currently receiving on quality improvement and performance measurement.

“(D) Current gaps in technical assistance for quality improvement and performance measurement.”.

(e) EFFECTIVE DATE.—Except as provided in subsection (b)(1)(C), the amendments made by this section shall apply to contracts entered into on or after August 1, 2009.

SEC. 6. FUNDING.

(a) IN GENERAL.—

(1) FUNDING.—Section 1159 of the Social Security Act (42 U.S.C. 1320c–8) is amended—

(A) in the matter preceding paragraph (1), by inserting “(a)” before “Expenses incurred’’;

and

(B) by adding at the end the following new subsections:

“(b) Subject to subsection (e), funding for contracts under this part shall be used solely for providing technical assistance for quality improvement and performance measurement. The decision whether to fund such contracts under this part shall be based on the results of evaluations conducted by the Secretary to determine—
“(1) the overall impact of the program under this part on quality improvement and performance measurement;

“(2) the specific quality improvement methods and techniques used by an organization;

“(3) which organizations that the Secretary contracts with under this part are most successful; and

“(4) whether there is continued demand for technical assistance for quality improvement and performance measurement, as demonstrated by—

“(A) demand by providers for such assistance;

“(B) the activities of utilization and quality control peer review organizations; and

“(C) referrals made by the Secretary, Medicare provider review organizations, and other agencies and organizations (including contractors) for such assistance.

“(c) Expenses incurred by Medicare provider review organizations in carrying out functions the responsibility for which was transferred under section 1164(a) shall be payable from funds authorized under subsection (a).”
(2) Effective date.—The amendments made by this subsection shall apply to contracts entered into on or after August 1, 2009.

(b) Limitations on Use and Reduction of Funding.—

(1) In general.—Section 1159 of the Social Security Act (42 U.S.C. 1320c–8), as amended by subsection (a), is amended—

(A) in subsection (b), by striking “subsection (c)” and inserting “subsections (c) and (d)”;

(B) by adding at the end the following new subsections:

“(d) Funding for contracts under this part may not be used for either of the following purposes:

“(1) To pay dues for membership in an organization that engages in lobbying activities (as defined in section 3 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1602)).

“(2) To pay fees to any individual for lobbying activities (as so defined).

“(e) The Secretary may not reduce the amount of funding under a contract under this part unless the scope of work has been reduced. In the case where the scope of work has been reduced, any reduction in contract fund-
ing shall be commensurate with the reduction in the scope of work.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date that is 1 year after the date of enactment of this Act.

SEC. 7. IMPROVEMENTS TO ANNUAL REPORTS.

Section 1161 of the Social Security Act (42 U.S.C. 1320c–1) is amended—

(1) in the matter preceding paragraph (1), by striking “the Congress” and inserting “the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the House of Representatives”;

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (7), respectively; and

(3) by inserting after paragraph (3) the following new paragraph:

“(4) in the case of reports submitted on or after April 1, 2010—

“(A) the number and type of practitioners and providers that are provided technical assistance for quality improvement and performance measurement under section 1154(g);

“(B) the performance of organizations under a contract under this part against per-
formance measures, including interim and final goals, developed under section 1153(i)(4);

“(C) the number and nature of complaints investigated by Medicare provider review organizations, and the disposition of such complaints by such organizations;

“(D) a compilation of the data contained in quality reports submitted to the Secretary under section 1164(c)(2)(D);

“(E) the amount and apportionment of funding from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to administer this part under section 1159, including how such funds were allocated based on the recipient, purpose, and amount; and

“(F) any weaknesses identified in audits conducted with respect to the financial statements of utilization and quality control peer review organizations and Medicare provider review organizations.”.